KANSAS METHAMPHETAMINE PRECURSOR SCHEDULING TASK FORCE LEGISLATIVE REPORT

Prepared by the
Kansas Methamphetamine Precursor
Scheduling Task Force Committee
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Executive Summary

The 2008 Legislature passed legislation (SB 491) that established a Methamphetamine Precursor Scheduling Task Force. The legislation created a multi-stakeholder committee that would study the possibility and practicality of making methamphetamine precursors a schedule III or IV drug. The study was to include the impact such a change would have on consumer access and cost.

The task force members are Michael Coast, R.Ph., Board of Pharmacy; Brian Caswell, R.Ph., Kansas Pharmacists Association; Dr. John Whitehead, Kansas Medical Society; Jeff Brandau, Kansas Bureau of Investigation; Mandy Hagan, Consumer Health Product Association; Dr. Margaret Smith, Kansas Health Policy Authority; Dr. Mary Franz, Kansas Association of Osteopathic Medicine; Dr. Michael Beezley, Kansas Board of Healing Arts; Steve Wilhoft, Kansas Attorney General's Office.

The task force opened the meeting and there were many stakeholders who attended the meetings and provided input.

I. Background

In 2005 the Kansas Legislature passed the Sheriff Matt Samuels Chemical Control Act (SB 27) scheduling all single and combination products that contained any amount of ephedrine or psuedoephedrine (PSE) that were in starch tablet form or gel coated as a Schedule V drug. Single active ingredient PSE or combination ephedrine and combination PSE products that were in liquid, capsule or gel-filled capsules were exempt and could continue to be sold over the counter at retail stores. The Combat Epidemic Act of 2005 further required that the sale of PSE or ephedrine be limited to 3.6 grams/day or 9 grams/month. A consumer purchasing a Schedule V drug was required to have the sale recorded in a logbook.

In 2007 the Kansas Legislature passed HB 2062 in order to reconcile provisions of the Sheriff Matt Samuels Chemical Control Act of 2005 to provisions of the federal Combat Methamphetamine Epidemic Act of 2005. Effective July 1, 2007 any compound, mixture, or preparation containing any detectable quantity of ephedrine or PSE were scheduled as a Schedule V and required to be sold at a pharmacy.

In 2008 the Kansas Legislature passed SB 491 establishing the Methamphetamine Precursor Scheduling Task Force. This report has been prepared for the Senate President and the Speaker of the House as required in the statute. The purpose of this report is to provide a detailed and comprehensive review of the Kansas Methamphetamine Precursor requirements and to provide any recommendations to the Legislature regarding the continued battle against illicit methamphetamine use.

II. Problem Defined

Alcohol and drug problems are among the most significant social issues this nation faces. Methamphetamine is a highly addictive central nervous system stimulant that can be injected, snorted, smoked or ingested orally. Methamphetamine users feel a short yet intense "rush" when the drug is initially administered. Long term use of methamphetamine can cause addiction, anxiety, insomnia, mood disturbances, and violent behavior. Additionally, psychotic symptoms such as paranoia, hallucinations, and delusions can occur.

Most methamphetamine is imported from other countries, but some of it is still produced in clandestine laboratories and distributed on the black market. These small toxic laboratories are still found throughout the state. Most of these laboratories operate using the "birch" method and can be found in many different locations, including residences, hotels, vehicles, and remote farm areas. The laboratory operators continue to purchase the necessary ingredients by going from store to store purchasing the maximum allowable amounts (a process known as "smurfing") and stealing other ingredients such as anhydrous ammonia. The ease of clandestine synthesis, combined with tremendous profits, has resulted in significant availability of illicit methamphetamine. Kansas has seen a 51 percent increase in methamphetamine labs just in the last year. Methamphetamine is manufactured using common household ingredients (precursor chemicals). Producers usually use cold medications containing ephedrine or pseudoephedrine as the main component. Other items used to cook methamphetamine include chemicals derived from drain cleaners, lithium batteries, lantern fuel, starter fluid, acetone, and anhydrous ammonia.

According to the 2007 National Survey on Drug Use and Health approximately 1.3 million Americans aged 12 or older reported using methamphetamine at least once during their lifetimes. This represents 5.3 percent of the population aged 12 or older. More than 1.3 million (0.5%) reported in the past year methamphetamine use and 529,000 (0.2%) reported past month methamphetamine use.

Clandestine labs present numerous hazards to people and the environment. There is an extreme potential for fires, explosions and exposure to hazardous chemicals and fumes. For every pound of methamphetamine produced about six pounds of hazardous wastes are left behind. The average cost of a clean up is about $5000 but can climb as high as $150,000 for a large scale lab.

The Drug Abuse Warning Network (DAWN) has estimated that of the 108 million emergency department visits in the United States during 2005 1,449,154 visits were associated with drug misuse or abuse. DAWN data also indicated that methamphetamine was involved in 108,905 of the drug related visits to the hospital.

Illicit methamphetamine use takes a toll on the state related to health care costs, environmental costs, criminal activity, and harm to families and children. The task force

also determined that approximately $680,000 (not counting the public defender's office) was spent on the indigent defense fund to defend methamphetamine and cocaine cases that are higher level felonies. These are level 1 and level 2 drug felonies. Much of this money is being used to defend meth manufacturers as well as the other drug crimes.

The Task Force agreed that the state has several choices. The state could do nothing, implement electronic tracking, schedule PSE and ephedrine as a schedule III or IV drug, or make PSE products a 3rd Class Drug. Each of these choices were reviewed and discussed in-depth.

III. Electronic Tracking Pilot Programs

The Task Force implemented two separate pilot programs in the state that would record PSE and ephedrine sales transactions electronically. The MethShield program was in the Southwest part of the state and at least 64 percent of the community pharmacies voluntarily participated in the pilot. The MethCheck program was conducted in the Southeast section of the state. Both projects were provided to the state at no cost.

One of the programs provided point of sale scanners and signature pads, but both were Internet based and the consumer sales were recorded electronically. Both systems will also block sales, or stop the sale, if the amount of PSE being purchased is in violation of the Combat Meth Act, so that a transaction cannot be completed. The Kentucky Office of Drug Control Policy did a presentation for the task force and they recommended that a stop sale system be implemented because it is difficult for law enforcement to investigate all illegal transactions. The transactions could then be submitted to required State interfaces such as law enforcement. The programs could provide real-time link analysis of individuals, mapping transactions, and email alerts for purchases. The pilot program indicated that there were still many illegal purchases occurring within the borders of Kansas. A small percentage of buyers were purchasing excessive quantities. The annual cost for such a program would be $300,000 to $350,000 a year.

Tracking easily enforces the legal limits and the states that have implemented electronic tracking have shown a dramatic reduction in meth labs. Most of the police departments involved with the study indicated that it was difficult to deal with the logbooks unless they were electronically maintained. It continues to allow access for the law abiding citizens and it eliminates smurfing. It also provided the tools necessary for a prosecutor to build a case against an individual who is gaining access for illegal purposes.

Both pilot projects showed that the local pharmacies were eager to participate to ensure that PSE was not sold in excess of the Combat Meth Act limits. The major chain stores in both pilot areas, i.e. Wal-Mart, Walgreens, etc., did not participate and statutory requirements would be needed to mandate their participation. With chain stores selling the bulk of the PSE products in the state statutory language would be required to ensure success of an electronic tracking program.

IV. Scheduling PSE and Ephedrine as Schedule III or IV

Oregon is the only state that has scheduled PSE and Ephedrine products as a Schedule III. A prescription is required for any consumer that would want to purchase a cold product that contains PSE or Ephedrine. Oregon has shown a reduction in meth labs but they did not have any statistical information to share regarding a reduction in costs to the consumer or the state.

There would be a reduction in sales tax if PSE were made a prescription drug. PSE sales in Kansas for the year ending December 31, 2008 (not including Wal-Mart) were:

Boxes: 483,543

Dollars: $4,926.334

Sales Tax: $261,095

The task force felt that while prescriptions would deter "smurfing" that it would be detrimental to the consumer. There would probably be an increase in "doctor shopping" or a violator would simply go to multiple doctors for a prescription. Scheduling PSE would decrease the current sales tax collected or additional taxes on products. Further, the physicians who were polled indicated that it would be a burden on prescribers to see each patient in order to write a prescription for cold medications. It would burden the consumer who could have additional co-pays for the physician visit and it was considered that many consumers may not even have a physician/patient relationship. The overall cost associated with the increase in insurance and obtaining health care is not the most effective use of state resources. Requiring a prescription would also burden the state's Medicaid and Medicare systems if a patient had to see a physician in order to obtain a cold medication. The task force did not view this option as one that would be a cost saving mechanism.

V. Third Class Drugs

The task force discussed the option of making all PSE and ephedrine products a third class drug. This would allow the pharmacist to write prescriptions and negate the necessity for a doctor's visit. There would be no additional cost to the consumer because there would be no co-pay and there would be no additional time taken from the physician. The Kansas Pharmacist Association and Kansas Independent Pharmacy Service Corporation surveyed their members about whether PSE and ephedrine products should be treated as a third class drug. About 1/3 of the members felt that there should be no change in the law related to making PSE a 3rd class drug. Another 1/3 supported making PSE a third class drug because this would not impede a law abiding patient from obtaining cold medication. The other 1/3 supported either a third class of drug or scheduling the PSE as a prescription only drug. Having a third class of drugs may be a viable option in the future for similar type drugs but it would probably not be the best way to solve the PSE problem at this time.

VI. Recommendation

The Kansas Methamphetamine Precursor Scheduling Task Force would respectfully submit their recommendation to the Kansas Legislature. After much discussion and study the Task Force would recommend that the state not maintain the status quo and the state should invest in an electronic real-time logbook system. The task force would emphasize that an electronic logbook would allow law abiding citizens the ability to have drugs that are used for common cold symptoms. The task force did not want to impede consumers from having the ability to treat themselves for the common cold. The cost associated with illicit methamphetamine activity is greater than the small amount needed to implement electronic tracking and this has proven to be effective. The current manual tracking that is now in place is labor intensive and not cost effective. The task force realized that the best use of state resources would be to require mandatory use of a real-time electronic tracking system by any pharmacy that is selling PSE or ephedrine products.